February 22, 2008

ENGROSSED
SENATE BILL No. 331

DIGEST OF SB 331 (Updated February 21, 2008 12:13 pm - DI 97)

Citations Affected: IC 27-4; IC 27-8; IC 27-13; noncode.

Synopsis: Health insurance. Defines "dependent" for purposes of the laws regulating policies of accident and sickness insurance and health maintenance organization contracts. Amends provisions related to coverage of dependents under a policy of accident and sickness insurance or a health maintenance organization contract. Specifies requirements for coverage of dialysis treatment under a policy of accident and sickness insurance or a health maintenance organization contract.

Effective: Upon passage; July 1, 2008.

Mishler, Smith S

(HOUSE SPONSORS — FRY, RIPLEY)

January 10, 2008, read first time and referred to Committee on Insurance and Financial Institutions.
January 24, 2008, reported favorably — Do Pass.
January 28, 2008, read second time, amended, ordered engrossed.
January 29, 2008, engrossed. Read third time, passed. Yeas 26, nays 22.

HOUSE ACTION

February 5, 2008, read first time and referred to Committee on Insurance.
February 21, 2008, amended, reported — Do Pass.

February 22, 2008

Second Regular Session 115th General Assembly (2008)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2007 Regular Session of the General Assembly.

ENGROSSED SENATE BILL No. 331

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-4-1-4, AS AMENDED BY P.L.131-2007, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement:

(A) misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon;

(B) making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies;

(C) making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(D) using any name or title of any policy or class of policies misrepresenting the true nature thereof; or

(E) making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender the policyholder's insurance.

(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading.

(3) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Entering into any agreement to commit, or individually or by a concerted action committing any act of boycott, coercion, or intimidation resulting or tending to result in unreasonable restraint of, or a monopoly in, the business of insurance.

(5) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive. Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to which such insurer is required by law to report, or which has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer.

(6) Issuing or delivering or permitting agents, officers, or

employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

(7) Making or permitting any of the following:

(A) Unfair discrimination between individuals of the same class and equal expectation of life in the rates or assessments charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract; however, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(B) Unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, assessments, or rates charged or made for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever; however, in determining the class, consideration may be given to the nature of the risk, the plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(C) Excessive or inadequate charges for premiums, policy fees, assessments, or rates, or making or permitting any unfair discrimination between persons of the same class involving essentially the same hazards, in the amount of premiums, policy fees, assessments, or rates charged or made for:

(i) policies or contracts of reinsurance or joint reinsurance, or abstract and title insurance;

(ii) policies or contracts of insurance against loss or damage to aircraft, or against liability arising out of the ownership, maintenance, or use of any aircraft, or of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance; or

(iii) policies or contracts of any other kind or kinds of insurance whatsoever.

However, nothing contained in clause (C) shall be construed to apply to any of the kinds of insurance referred to in clauses (A)

and (B) nor to reinsurance in relation to such kinds of insurance. Nothing in clause (A), (B), or (C) shall be construed as making or permitting any excessive, inadequate, or unfairly discriminatory charge or rate or any charge or rate determined by the department or commissioner to meet the requirements of any other insurance rate regulatory law of this state.

(8) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract or policy of insurance of any kind or kinds whatsoever, including but not in limitation, life annuities, or agreement as to such contract or policy other than as plainly expressed in such contract or policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends, savings, or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract or policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, limited liability company, or partnership, or any dividends, savings, or profits accrued thereon, or anything of value whatsoever not specified in the contract. Nothing in this subdivision and subdivision (7) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(A) Paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, so long as any such bonuses or abatement of premiums are fair and equitable to policyholders and for the best interests of the company and its policyholders.

(B) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.

(C) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first year or of any subsequent year of insurance thereunder, which may be made retroactive only for such policy year.

(D) Paying by an insurer or insurance producer thereof duly licensed as such under the laws of this state of money, commission, or brokerage, or giving or allowing by an insurer or such licensed insurance producer thereof anything of value, for or on account of the solicitation or negotiation of policies or other contracts of any kind or kinds, to a broker, an insurance producer, or a solicitor duly licensed under the laws of this state, but such broker, insurance producer, or solicitor receiving such consideration shall not pay, give, or allow credit for such consideration as received in whole or in part, directly or indirectly, to the insured by way of rebate.

(9) Requiring, as a condition precedent to loaning money upon the security of a mortgage upon real property, that the owner of the property to whom the money is to be loaned negotiate any policy of insurance covering such real property through a particular insurance producer or broker or brokers. However, this subdivision shall not prevent the exercise by any lender of the lender's right to approve or disapprove of the insurance company selected by the borrower to underwrite the insurance.

(10) Entering into any contract, combination in the form of a trust or otherwise, or conspiracy in restraint of commerce in the business of insurance.

(11) Monopolizing or attempting to monopolize or combining or conspiring with any other person or persons to monopolize any part of commerce in the business of insurance. However, participation as a member, director, or officer in the activities of any nonprofit organization of insurance producers or other workers in the insurance business shall not be interpreted, in itself, to constitute a combination in restraint of trade or as combining to create a monopoly as provided in this subdivision and subdivision (10). The enumeration in this chapter of specific unfair methods of competition and unfair or deceptive acts and practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the commissioner or department or of any court of review under section 8 of this chapter.

(12) Requiring as a condition precedent to the sale of real or personal property under any contract of sale, conditional sales contract, or other similar instrument or upon the security of a chattel mortgage, that the buyer of such property negotiate any policy of insurance covering such property through a particular insurance company, insurance producer, or broker or brokers.

However, this subdivision shall not prevent the exercise by any seller of such property or the one making a loan thereon of the right to approve or disapprove of the insurance company selected by the buyer to underwrite the insurance.

(13) Issuing, offering, or participating in a plan to issue or offer, any policy or certificate of insurance of any kind or character as an inducement to the purchase of any property, real, personal, or mixed, or services of any kind, where a charge to the insured is not made for and on account of such policy or certificate of insurance. However, this subdivision shall not apply to any of the following:

(A) Insurance issued to credit unions or members of credit unions in connection with the purchase of shares in such credit unions.

(B) Insurance employed as a means of guaranteeing the performance of goods and designed to benefit the purchasers or users of such goods.

(C) Title insurance.

(D) Insurance written in connection with an indebtedness and intended as a means of repaying such indebtedness in the event of the death or disability of the insured.

(E) Insurance provided by or through motorists service clubs or associations.

(F) Insurance that is provided to the purchaser or holder of an air transportation ticket and that:

(i) insures against death or nonfatal injury that occurs during the flight to which the ticket relates;

(ii) insures against personal injury or property damage that occurs during travel to or from the airport in a common carrier immediately before or after the flight;

(iii) insures against baggage loss during the flight to which the ticket relates; or

(iv) insures against a flight cancellation to which the ticket relates.

(14) Refusing, because of the for-profit status of a hospital or medical facility, to make payments otherwise required to be made under a contract or policy of insurance for charges incurred by an insured in such a for-profit hospital or other for-profit medical facility licensed by the state department of health.

(15) Refusing to insure an individual, refusing to continue to issue insurance to an individual, limiting the amount, extent, or kind of coverage available to an individual, or charging an individual a

different rate for the same coverage, solely because of that individual's blindness or partial blindness, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(16) Committing or performing, with such frequency as to indicate a general practice, unfair claim settlement practices (as defined in section 4.5 of this chapter).

(17) Between policy renewal dates, unilaterally canceling an individual's coverage under an individual or group health insurance policy solely because of the individual's medical or physical condition.

(18) Using a policy form or rider that would permit a cancellation of coverage as described in subdivision (17).

(19) Violating IC 27-1-22-25, IC 27-1-22-26, or IC 27-1-22-26.1 concerning motor vehicle insurance rates.

(20) Violating IC 27-8-21-2 concerning advertisements referring to interest rate guarantees.

(21) Violating IC 27-8-24.3 concerning insurance and health plan coverage for victims of abuse.

(22) Violating IC 27-8-26 concerning genetic screening or testing.

(23) Violating IC 27-1-15.6-3(b) concerning licensure of insurance producers.

(24) Violating IC 27-1-38 concerning depository institutions.

(25) Violating IC 27-8-28-17(c) or IC 27-13-10-8(c) concerning the resolution of an appealed grievance decision.

(26) Violating IC 27-8-5-2.5(e) through IC 27-8-5-2.5(j) or IC 27-8-5-19.2.

(27) Violating IC 27-2-21 concerning use of credit information.

(28) Violating IC 27-4-9-3 concerning recommendations to consumers.

(29) Engaging in dishonest or predatory insurance practices in marketing or sales of insurance to members of the United States Armed Forces as:

(A) described in the federal Military Personnel Financial Services Protection Act, P.L.109-290; or

(B) defined in rules adopted under subsection (b).

(30) Violating IC 27-8-11-10, IC 27-8-11.1, or IC 27-13-15-5 concerning dialysis treatment.

(b) Except with respect to federal insurance programs under Subchapter III of Chapter 19 of Title 38 of the United States Code, the commissioner may, consistent with the federal Military Personnel

Financial Services Protection Act (P.L.109-290), adopt rules under IC 4-22-2 to:

(1) define; and

(2) while the members are on a United States military installation or elsewhere in Indiana, protect members of the United States Armed Forces from;

dishonest or predatory insurance practices.

SECTION 2. IC 27-8-5-1, AS AMENDED BY P.L.173-2007, SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 1. (a) The term "policy of accident and sickness insurance", as used in this chapter, includes any policy or contract covering one (1) or more of the kinds of insurance described in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the individual basis under this section and sections 2 through 9 of this chapter, on the group basis under this section and sections 16 through 19 of this chapter, on the franchise basis under this section and section 11 of this chapter, or on a blanket basis under section 15 of this chapter and (except as otherwise expressly provided in this chapter) shall be exclusively governed by this chapter.

(b) As used in this chapter, "dependent" means, with respect to a policyholder or certificate holder, an individual who:

(1) is:

(A) a biological or legally adopted child of the policyholder or certificate holder who receives any support from the policyholder or certificate holder; or

(B) an individual for whom the policyholder or certificate holder has a legal guardianship or who is a stepchild, grandchild, or other blood relative of the policyholder or certificate holder and who receives more than fifty percent (50%) of the individual's total support from the policyholder or certificate holder;

(2) resides with the policyholder or certificate holder at least six (6) months of the year, with exceptions for divorce, separation, or temporary absences, including absences for illness, education, business, vacation, or military service;

(3) is unmarried;

(4) is not eligible for group coverage for health care services through the individual's employer; and

(5) does not have coverage for health care services.

(c) An insurer may annually require proof of financial dependency of an individual described in subsection (b)(1)(B).

~~(b)~~ **(d)** No policy of accident and sickness insurance may be issued

or delivered to any person in this state, nor may any application, rider, or endorsement be used in connection with an accident and sickness insurance policy, until a copy of the form of the policy and of the classification of risks and the premium rates, or, in the case of assessment companies, the estimated cost pertaining thereto, have been filed with and reviewed by the commissioner under section 1.5 of this chapter. This section is applicable also to assessment companies and fraternal benefit associations or societies.

SECTION 3. IC 27-8-5-2, AS AMENDED BY P.L.218-2007, SECTION 45, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 2. (a) No individual policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless it complies with each of the following:

(1) The entire money and other considerations for the policy are expressed in the policy.

(2) The time at which the insurance takes effect and terminates is expressed in the policy.

(3) The policy purports to insure only one (1) person, except that a policy must insure **at the request of the policyholder,** originally or by subsequent amendment, ~~upon the application of any member of a family who shall be deemed the policyholder and who is at least eighteen (18) years of age,~~ any two (2) or more eligible members of that family, including: ~~husband, wife, dependent children, or any children who are less than~~

(A) a spouse; and

(B) a dependent of the:

(i) policyholder; or

(ii) policyholder's spouse;

until the date the dependent becomes twenty-four (24) years of age. ~~and any other person dependent upon the policyholder.~~

(4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightface type of a style in general use, the size of which shall be uniform and not less than ten point with a lower-case unspaced alphabet length not less than one hundred and twenty point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions).

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 3 of this

chapter, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.

(6) Each such form of the policy, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page of the policy.

(7) The policy contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short-rate table filed with the commissioner.

(8) **Notwithstanding subdivision (3),** if an individual accident and sickness insurance policy or hospital service plan contract or medical service plan contract provides that hospital or medical expense coverage of a dependent ~~child~~ terminates upon attainment of the limiting age for ~~dependent children~~ **dependents** specified in such policy or contract, the policy or contract must also provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of ~~such child~~ **the dependent** while the ~~child~~ **dependent** is and continues to be both:

(A) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

(B) chiefly dependent upon the policyholder for support and maintenance.

Proof of such incapacity and dependency must be furnished to the insurer by the policyholder within thirty-one (31) days of the ~~child's~~ **dependent's** attainment of the limiting age. The insurer may require at reasonable intervals during the two (2) years following the ~~child's~~ **dependent's** attainment of the limiting age subsequent proof of the ~~child's~~ **dependent's** disability and dependency. After such two (2) year period, the insurer may require subsequent proof not more than once each year. The foregoing provision shall not require an insurer to insure a dependent who ~~is a child who~~ has mental retardation or a mental or physical disability where such dependent does not satisfy the conditions of the policy provisions as may be stated in the policy or contract required for coverage thereunder to take effect. In any

such case the terms of the policy or contract shall apply with regard to the coverage or exclusion from coverage of such dependent. This subsection applies only to policies or contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after August 18, 1969.

(b) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection (a) and in section 3 of this chapter.

(c) An insurer may issue a policy described in this section in electronic or paper form. However, the insurer shall:

(1) inform the insured that the insured may request the policy in paper form; and

(2) issue the policy in paper form upon the request of the insured.

SECTION 4. IC 27-8-5-18 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 18. (a) Except for a policy that conforms to the description in section 16(2) of this chapter, a group accident and sickness insurance policy may be extended to insure the employees or members, or any class or classes of employees or members, with respect to their family members or dependents, subject to subsections (b) and (c).

(b) The premium for the insurance must be paid from funds contributed by the employer, union, association, or other person to whom the policy has been issued or from funds contributed by the covered persons, or from both sources of funds. Except as provided in subsection (c), a policy on which no part of the premium for the coverage of family members or dependents is to be derived from funds contributed by the covered persons must insure all eligible employees or members, or any class or classes of eligible employees or members, with respect to their spouses and ~~dependent children.~~ **dependents.**

(c) Except as provided in section 24 of this chapter, an insurer may exclude or limit the coverage on any family member or dependent as to whom evidence of individual insurability is not satisfactory to the insurer.

SECTION 5. IC 27-8-5-19, AS AMENDED BY P.L.173-2007, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 19. (a) As used in this chapter, "late enrollee" has the meaning set forth in 26 U.S.C. 9801(b)(3).

(b) A policy of group accident and sickness insurance may not be

issued to a group that has a legal situs in Indiana unless it contains in substance:

(1) the provisions described in subsection (c); or

(2) provisions that, in the opinion of the commissioner, are:

(A) more favorable to the persons insured; or

(B) at least as favorable to the persons insured and more favorable to the policyholder;

than the provisions set forth in subsection (c).

(c) The provisions referred to in subsection (b)(1) are as follows:

(1) A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy will continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period. A provision under this subdivision may provide that the insurer is not obligated to pay claims incurred during the grace period until the premium due is received.

(2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless:

(A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or

(B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.

(3) A provision that a copy of the application, if there is one, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has

been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

(5) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy and that is not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice, diagnosis, care, or treatment was received by the person or recommended to the person during the six (6) months before the effective date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of:

(i) the end of a continuous period of twelve (12) months beginning on or after the effective date of the person's coverage; or

(ii) the end of a continuous period of eighteen (18) months beginning on the effective date of the person's coverage if the person is a late enrollee.

This subdivision applies only to group policies of accident and sickness insurance other than those described in section 2.5(a)(1) through 2.5(a)(8) and 2.5(b)(2) of this chapter.

(6) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice or treatment was received by the person during a period of three hundred sixty-five (365) days before the effective date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning

after the earlier of the following:

(i) The end of a continuous period of three hundred sixty-five (365) days, beginning on or after the effective date of the person's coverage, during which the person did not receive medical advice or treatment in connection with the disease or physical condition.

(ii) The end of the two (2) year period beginning on the effective date of the person's coverage.

This subdivision applies only to group policies of accident and sickness insurance described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.

(7) If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

(A) premiums;

(B) benefits; or

(C) both premiums and benefits;

to be made if the age of a covered person has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be used.

(8) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate, in electronic or paper form, setting forth a statement that:

(A) explains the insurance protection to which the person insured is entitled;

(B) indicates to whom the insurance benefits are payable; and

(C) explains any family member's or dependent's coverage under the policy.

The provision must specify that the certificate will be provided in paper form upon the request of the insured.

(9) A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

(10) A provision stating that:

(A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim, forms usually furnished by the insurer for filing proof of loss; and

(B) if the forms are not furnished within fifteen (15) days after

the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

(11) A provision stating that:

(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;

(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and

(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.

(12) A provision that:

(A) all benefits payable under the policy (other than benefits for loss of time) will be paid:

(i) not more than forty-five (45) days after the insurer's (as defined in IC 27-8-5.7-3) receipt of written proof of loss if the claim is filed by the policyholder; or

(ii) in accordance with IC 27-8-5.7 if the claim is filed by the provider (as defined in IC 27-8-5.7-4); and

(B) subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.

(13) A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of benefits for loss of life is

subject to the provisions of the policy if no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount of five thousand dollars ($5,000), to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit.

(14) A provision that the insurer, at the insurer's expense, has the right and must be allowed the opportunity to:

(A) examine the person of the individual for whom a claim is made under the policy when and as often as the insurer reasonably requires during the pendency of the claim; and

(B) conduct an autopsy in case of death if it is not prohibited by law.

(15) A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of loss is filed in accordance with the requirements of the policy and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required by the policy.

(16) In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

(17) **Notwithstanding section 28 of this chapter,** if the policy provides that hospital or medical expense coverage of a dependent ~~child~~ of a group member terminates upon the ~~child's~~ **dependent's** attainment of the limiting age for ~~dependent children~~ **dependents** set forth in the policy, a provision that the ~~child's~~ **dependent's** attainment of the limiting age does not terminate the hospital and medical coverage of the ~~child~~ **dependent** while the ~~child~~ **dependent** is:

(A) incapable of self-sustaining employment because of mental retardation or mental or physical disability; and

(B) chiefly dependent upon the group member for support and maintenance.

A provision under this subdivision may require that proof of the ~~child's~~ **dependent's** incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120)

days of the ~~child's~~ **dependent's** attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the ~~child's~~ **dependent's** attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the ~~child's~~ **dependent's** attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a ~~child~~ **dependent** who has mental retardation or a mental or physical disability who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the ~~child.~~ **dependent.**

(18) A provision that complies with the group portability and guaranteed renewability provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191).

(d) Subsection (c)(5), (c)(8), and (c)(13) do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.

(e) If any policy provision required under subsection (c) is in whole or in part inapplicable to or inconsistent with the coverage provided by an insurer under a particular form of policy, the insurer, with the approval of the commissioner, shall delete the provision from the policy or modify the provision in such a manner as to make it consistent with the coverage provided by the policy.

(f) An insurer that issues a policy described in this section shall include in the insurer's enrollment materials information concerning the manner in which an individual insured under the policy may:

(1) obtain a certificate described in subsection (c)(8); and

(2) request the certificate in paper form.

SECTION 6. IC 27-8-5-28, AS ADDED BY P.L.218-2007, SECTION 48, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 28. A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a ~~child~~ **dependent** of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the ~~child~~ **dependent** becomes twenty-four (24) years of age.

SECTION 7. IC 27-8-5-29 IS ADDED TO THE INDIANA CODE

AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: **Sec. 29. An insurer shall, for purposes of coverage of a dependent of a policyholder or certificate holder under this chapter, do all of the following:**

(1) Provide to each policyholder or certificate holder at the time of application, amendment, or renewal of a policy of accident and sickness insurance written notice that:

(A) is provided in a document that is separate from any other document provided to the policyholder or certificate holder; and

(B) clearly explains:

(i) that a dependent of the policyholder or certificate holder will be covered upon the request of the policyholder or certificate holder; and

(ii) the manner and form in which the policyholder or certificate holder must request the coverage.

(2) Allow at least thirty (30) days after a policyholder or certificate holder receives the notice required by subdivision (1) for the policyholder or certificate holder to make a request for the coverage.

(3) If:

(A) the dependent's coverage was previously terminated due to the dependent's age; and

(B) the dependent is not yet twenty-four (24) years of age; allow the dependent to re-enroll for coverage under the policyholder's or certificate holder's policy or certificate.

(4) Comply with the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) concerning exclusions or limitations of coverage related to a disease or physical condition of the dependent that exists before re-enrollment under subdivision (3).

SECTION 8. IC 27-8-11-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 10. (a) The definitions in IC 27-8-11.1 apply throughout this section.**

(b) An agreement entered into under section 3 of this chapter after April 30, 2008, must provide that if the insurer fails to pay, as specified by the agreement, for health care services rendered at a network dialysis facility, the insured is not liable for any sums owed by the insurer.

SECTION 9. IC 27-8-11.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE

UPON PASSAGE]:

Chapter 11.1. Dialysis Treatment

Sec. 1. Except as provided in this chapter, the definitions in IC 27-8-11-1 apply throughout this chapter.

Sec. 2. As used in this chapter, "dialysis facility" means an outpatient facility in Indiana at which a dialysis treatment provider renders dialysis treatment.

Sec. 3. As used in this chapter, "insured" refers only to an insured who requires dialysis treatment.

Sec. 4. As used in this chapter, "insurer" includes the following:

(1) An administrator licensed under IC 27-1-25.

(2) An agent of an insurer.

Sec. 5. As used in this chapter, "network" refers to a group of providers, each of which has:

(1) individually; or

(2) as a member of a group;

entered into an agreement with a particular insurer under IC 27-8-11-3.

Sec. 6. As used in this chapter, "network dialysis facility" means a dialysis facility that has entered into an agreement with a particular insurer under IC 27-8-11-3.

Sec. 7. As used in this chapter, "out of network dialysis facility" means a dialysis facility that has not entered into an agreement with a particular insurer under IC 27-8-11-3.

Sec. 8. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. The term does not include the following:

(1) Accident-only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy issued as an individual policy.

(6) A limited benefit health insurance policy issued as an individual policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

Sec. 9. To the extent that IC 27-8-11-4.5(c) and IC 27-8-11-4.5(d)

conflict with the requirements of this chapter, IC 27-8-11-4.5(c) and IC 27-8-11-4.5(d) do not apply with respect to the requirements of this chapter.

Sec. 10. A policy of accident and sickness insurance must provide coverage for dialysis treatment regardless of whether an insured obtains dialysis treatment from a network dialysis facility or an out of network dialysis facility.

Sec. 11. An insurer that uses a network shall establish a payment rate for a health care service rendered by a dialysis treatment provider at an out of network dialysis facility:

(1) in consultation with the dialysis treatment provider; and

(2) based on the following:

(A) The type of health care service rendered.

(B) The fees usually charged by the dialysis treatment provider.

(C) The prevailing rate paid to a dialysis treatment provider by insurers in the same geographic area during the preceding twelve (12) months.

Sec. 12. In establishing a payment rate under section 11 of this chapter, an insurer shall:

(1) not consider Medicaid and Medicare payment rates; and

(2) establish the payment rate at an amount equal to not less than the greatest of the following payment rates paid by the insurer during the previous twelve (12) months:

(A) The highest payment rate paid to the dialysis treatment provider for health care services rendered at a network dialysis facility.

(B) The highest payment rate paid to the dialysis treatment provider for health care services rendered at an out of network dialysis facility.

(C) The highest payment rate paid to any dialysis treatment provider for health care services rendered at a network dialysis facility.

Sec. 13. An insurer may not do any of the following at any time after an insured elects coverage under a policy of accident and sickness insurance:

(1) Restrict benefits or increase costs to the insured in relation to dialysis treatment, including the insured's out-of-pocket expenses.

(2) Change coverage or benefits in any way that would affect dialysis treatment provided at an out of network dialysis facility.

Sec. 14. An insurer shall not do the following:

(1) Make changes in coverage under a policy of accident and sickness in an attempt to cause an insured to elect Medicare as the insured's primary coverage.

(2) Require an insured, as a condition of coverage, to travel more than fifteen (15) miles or for longer than thirty (30) minutes from the insured's home to obtain dialysis treatment, regardless of whether the insured chooses to receive dialysis treatment at a network dialysis facility or an out of network dialysis facility.

Sec. 15. An insurer shall do the following:

(1) Make all claim payments for health care services provided by a dialysis treatment provider payable only to the dialysis treatment provider and not to the insured, regardless of whether the health care services are rendered in a network dialysis facility or an out of network dialysis facility.

(2) File with the department, not later than December 31 of each year, an annual evaluation of the following:

(A) Whether the insurer's network of all dialysis treatment providers is sufficient to provide health care services to insureds covered under a policy of accident and sickness insurance issued by the insurer.

(B) A detailed analysis of whether the requirements of section 14(2) of this chapter are reflected in the actual distance and travel time required for insureds to obtain dialysis treatment.

(3) Maintain a network that at all times includes not less than fifty percent (50%) of the dialysis facilities in the geographic area in which health care services are provided by the network.

Sec. 16. The commissioner shall, not more than thirty (30) days after receiving a filing under section 15(2) of this chapter, approve the filing or make recommendations for changes to the network.

Sec. 17. The department may adopt rules under IC 4-22-2 to implement this section.

SECTION 10. IC 27-13-1-11.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: **Sec. 11.5. (a) "Dependent" means, with respect to a subscriber, an individual who:**

(1) is:

(A) a biological or legally adopted child of the subscriber who receives any support from the subscriber; or

(B) an individual for whom the subscriber is a legal guardian or who is a stepchild, grandchild, or other blood relative of the subscriber and who receives more than fifty percent (50%) of the individual's total support from the subscriber;

(2) resides with the subscriber at least six (6) months of the year, with exceptions for divorce, separation, or temporary absences, including absences for illness, education, business, vacation, or military service;

(3) is unmarried;

(4) is not eligible for group coverage for health care services through the individual's employer; and

(5) does not have coverage for health care services.

(b) A health maintenance organization may annually require proof of financial dependency of an individual described in subsection (a)(1)(B).

SECTION 11. IC 27-13-1-11.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 11.6. "Dialysis facility" means an outpatient facility in Indiana at which a dialysis treatment provider renders dialysis treatment.**

SECTION 12. IC 27-13-7-3, AS AMENDED BY P.L.218-2007, SECTION 50, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 3. (a) A contract referred to in section 1 of this chapter must clearly state the following:

(1) The name and address of the health maintenance organization.
(2) Eligibility requirements.
(3) Benefits and services within the service area.
(4) Emergency care benefits and services.
(5) Any out-of-area benefits and services.
(6) Copayments, deductibles, and other out-of-pocket costs.
(7) Limitations and exclusions.
(8) Enrollee termination provisions.
(9) Any enrollee reinstatement provisions.
(10) Claims procedures.
(11) Enrollee grievance procedures.
(12) Continuation of coverage provisions.
(13) Conversion provisions.
(14) Extension of benefit provisions.
(15) Coordination of benefit provisions.
(16) Any subrogation provisions.
(17) A description of the service area.

(18) The entire contract provisions.

(19) The term of the coverage provided by the contract.

(20) Any right of cancellation of the group or individual contract holder.

(21) Right of renewal provisions.

(22) Provisions regarding reinstatement of a group or an individual contract holder.

(23) Grace period provisions.

(24) A provision on conformity with state law.

(25) A provision or provisions that comply with the:

(A) guaranteed renewability; and

(B) group portability;

requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

(26) That the contract provides, upon request of the subscriber, coverage for a ~~child~~ **dependent** of the subscriber until the date the ~~child~~ **dependent** becomes twenty-four (24) years of age.

(b) For purposes of subsection (a), an evidence of coverage which is filed with a contract may be considered part of the contract.

(c) A health maintenance organization shall, for purposes of coverage of a dependent of a subscriber as required by subsection (a)(26), do all of the following:

(1) Provide to each subscriber at the time of application, amendment, or renewal of a contract referred to in section 1 of this chapter written notice that:

(A) is provided in a document that is separate from any other document provided to the subscriber; and

(B) clearly explains:

(i) that a dependent of the subscriber will be covered upon the request of the subscriber; and

(ii) the manner and form in which the subscriber must request the coverage.

(2) Allow at least thirty (30) days after a subscriber receives the notice required by subdivision (1) for the subscriber to make a request for the coverage.

(3) If:

(A) the dependent's coverage was previously terminated due to the dependent's age; and

(B) the dependent is not yet twenty-four (24) years of age; allow the dependent to re-enroll for coverage under the subscriber's individual contract or group contract.

(4) Comply with the federal Health Insurance Portability and

Accountability Act of 1996 (P.L. 104-191) concerning exclusions or limitations of coverage related to a disease or physical condition of the dependent that exists before re-enrollment under subdivision (3).

SECTION 13. IC 27-13-15-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 5. (a) Notwithstanding IC 27-13-1-12, as used in this section, "enrollee" refers only to an enrollee who requires dialysis treatment.**

(b) As used in this section, "health maintenance organization" includes the following:

(1) A limited service health maintenance organization.

(2) An agent of a health maintenance organization or a limited service health maintenance organization.

(c) To the extent that IC 27-13-15-1(b) and IC 27-13-15-1(c) conflict with the requirements of this section, IC 27-13-15-1(b) and IC 27-13-15-1(c) do not apply with respect to the requirements of this section.

(d) An individual contract or a group contract must provide coverage for dialysis treatment regardless of whether the dialysis facility from which an enrollee obtains dialysis treatment is a participating provider.

(e) A health maintenance organization shall establish a payment rate for a health care service rendered by a dialysis treatment provider at a dialysis facility that is not a participating provider:

(1) in consultation with the dialysis treatment provider; and

(2) based on the following:

(A) The type of health care service rendered.

(B) The fees usually charged by the dialysis treatment provider.

(C) The prevailing rate paid to a dialysis treatment provider by health maintenance organizations in the same geographic area during the preceding twelve (12) months.

(f) In establishing a payment rate under subsection (e), a health maintenance organization shall:

(1) not consider Medicaid and Medicare payment rates; and

(2) establish the payment rate at an amount equal to not less than the greatest of the following payment rates paid by the health maintenance organization during the previous twelve (12) months:

(A) The highest payment rate paid to the dialysis treatment provider for health care services rendered at a dialysis

facility that is a participating provider.

(B) The highest payment rate paid to the dialysis treatment provider for health care services rendered at a dialysis facility that is not a participating provider.

(C) The highest payment rate paid to any dialysis treatment provider for health care services rendered at a dialysis facility that is a participating provider.

(g) A health maintenance organization may not do any of the following at any time after an enrollee elects coverage under an individual contract or a group contract:

(1) Restrict benefits or increase costs to the enrollee in relation to dialysis treatment, including the enrollee's out-of-pocket expenses.

(2) Change coverage or benefits in any way that would affect dialysis treatment rendered at a dialysis facility that is not a participating provider.

(h) A health maintenance organization shall not do the following:

(1) Make changes in coverage under an individual contract or a group contract in an attempt to cause an enrollee to elect Medicare as the enrollee's primary coverage.

(2) Require an enrollee, as a condition of coverage, to travel more than fifteen (15) miles or for longer than thirty (30) minutes from the enrollee's home to obtain dialysis treatment, regardless of whether the enrollee chooses to receive dialysis treatment at a dialysis facility that is a participating provider or a dialysis facility that is not a participating provider.

(i) A health maintenance organization shall do the following:

(1) Make all claim payments for health care services provided by a dialysis treatment provider payable only to the dialysis treatment provider and not to the enrollee, regardless of whether the health care services are provided in a dialysis facility that is a participating provider or a dialysis facility that is not a participating provider.

(2) File with the department, not later than December 31 of each year, an annual evaluation of the following:

(A) Whether the health maintenance organization's network of all dialysis treatment providers is sufficient to provide health care services to enrollees covered under an individual contract or a group contract entered into by the health maintenance organization.

(B) A detailed analysis of whether the requirements of

subsection (h)(2) are reflected in the actual distance and travel time required for enrollees to obtain dialysis treatment.

(3) Maintain a participating provider network that at all times includes not less than fifty percent (50%) of the dialysis facilities in the health maintenance organization's service area.

(j) The commissioner shall, not more than thirty (30) days after receiving a filing under subsection (i)(2), approve the filing or make recommendations for changes to the network.

(k) The department may adopt rules under IC 4-22-2 to implement this section.

SECTION 14. [EFFECTIVE JULY 1, 2008] **(a) IC 27-8-5-1, IC 27-8-5-2, IC 27-8-5-18, IC 27-8-5-19, and IC 27-8-5-28, all as amended by this act, apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2008.**

(b) IC 27-13-1-11.5, as added by this act, and IC 27-13-7-3, as amended by this act, apply to an individual contract or a group contract that is entered into, delivered, amended, or renewed after June 30, 2008.

SECTION 15. **An emergency is declared for this act.**

SENATE MOTION

Madam President: I move that Senator Smith S be added as coauthor of Senate Bill 331.

MISHLER

COMMITTEE REPORT

Madam President: The Senate Committee on Insurance and Financial Institutions, to which was referred Senate Bill No. 331, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill DO PASS.

(Reference is made to Senate Bill 331 as introduced.)

PAUL, Chairperson

Committee Vote: Yeas 10, Nays 0.

SENATE MOTION

Madam President: I move that Senate Bill 331 be amended to read as follows:

Page 2, line 1, after "certificate holder" insert "**has a legal guardianship or who**".

Page 2, line 2, delete "legal guardian,".

Page 2, line 3, after "relative" insert "**of the policyholder or certificate holder and**".

Page 2, line 4, delete "individual's" and insert "**dependent's**".

Page 2, line 6, delete "is an Indiana resident;" and insert "**resides with the policyholder or certificate holder at least six (6) months of the year, with exceptions for divorce, separation, or temporary absences, including absences for illness, education, business, vacation, or military service;**".

Page 2, line 32, delete "insure," and insert "insure **at the request of the policy holder,**".

Page 2, line 36, delete "including," and insert "including:".

Page 2, line 37, delete "at the request of the policyholder:".

(Reference is to SB 331 as printed January 25, 2008.)

MISHLER

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred Senate Bill 331, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 12. IC 27-4-1-4, AS AMENDED BY P.L.131-2007, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement:

(A) misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon;

(B) making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies;

(C) making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(D) using any name or title of any policy or class of policies misrepresenting the true nature thereof; or

(E) making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender the policyholder's insurance.

(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading.

(3) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making,

publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Entering into any agreement to commit, or individually or by a concerted action committing any act of boycott, coercion, or intimidation resulting or tending to result in unreasonable restraint of, or a monopoly in, the business of insurance.

(5) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive. Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to which such insurer is required by law to report, or which has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer.

(6) Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

(7) Making or permitting any of the following:

(A) Unfair discrimination between individuals of the same class and equal expectation of life in the rates or assessments charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract; however, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(B) Unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, assessments, or rates charged or made

for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever; however, in determining the class, consideration may be given to the nature of the risk, the plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(C) Excessive or inadequate charges for premiums, policy fees, assessments, or rates, or making or permitting any unfair discrimination between persons of the same class involving essentially the same hazards, in the amount of premiums, policy fees, assessments, or rates charged or made for:

(i) policies or contracts of reinsurance or joint reinsurance, or abstract and title insurance;

(ii) policies or contracts of insurance against loss or damage to aircraft, or against liability arising out of the ownership, maintenance, or use of any aircraft, or of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance; or

(iii) policies or contracts of any other kind or kinds of insurance whatsoever.

However, nothing contained in clause (C) shall be construed to apply to any of the kinds of insurance referred to in clauses (A) and (B) nor to reinsurance in relation to such kinds of insurance. Nothing in clause (A), (B), or (C) shall be construed as making or permitting any excessive, inadequate, or unfairly discriminatory charge or rate or any charge or rate determined by the department or commissioner to meet the requirements of any other insurance rate regulatory law of this state.

(8) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract or policy of insurance of any kind or kinds whatsoever, including but not in limitation, life annuities, or agreement as to such contract or policy other than as plainly expressed in such contract or policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends, savings, or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract or policy; or giving, or selling, or purchasing or offering to give, sell, or

purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, limited liability company, or partnership, or any dividends, savings, or profits accrued thereon, or anything of value whatsoever not specified in the contract. Nothing in this subdivision and subdivision (7) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(A) Paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, so long as any such bonuses or abatement of premiums are fair and equitable to policyholders and for the best interests of the company and its policyholders.

(B) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.

(C) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first year or of any subsequent year of insurance thereunder, which may be made retroactive only for such policy year.

(D) Paying by an insurer or insurance producer thereof duly licensed as such under the laws of this state of money, commission, or brokerage, or giving or allowing by an insurer or such licensed insurance producer thereof anything of value, for or on account of the solicitation or negotiation of policies or other contracts of any kind or kinds, to a broker, an insurance producer, or a solicitor duly licensed under the laws of this state, but such broker, insurance producer, or solicitor receiving such consideration shall not pay, give, or allow credit for such consideration as received in whole or in part, directly or indirectly, to the insured by way of rebate.

(9) Requiring, as a condition precedent to loaning money upon the security of a mortgage upon real property, that the owner of the property to whom the money is to be loaned negotiate any policy of insurance covering such real property through a particular insurance producer or broker or brokers. However, this subdivision shall not prevent the exercise by any lender of the lender's right to approve or disapprove of the insurance company

selected by the borrower to underwrite the insurance.

(10) Entering into any contract, combination in the form of a trust or otherwise, or conspiracy in restraint of commerce in the business of insurance.

(11) Monopolizing or attempting to monopolize or combining or conspiring with any other person or persons to monopolize any part of commerce in the business of insurance. However, participation as a member, director, or officer in the activities of any nonprofit organization of insurance producers or other workers in the insurance business shall not be interpreted, in itself, to constitute a combination in restraint of trade or as combining to create a monopoly as provided in this subdivision and subdivision (10). The enumeration in this chapter of specific unfair methods of competition and unfair or deceptive acts and practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the commissioner or department or of any court of review under section 8 of this chapter.

(12) Requiring as a condition precedent to the sale of real or personal property under any contract of sale, conditional sales contract, or other similar instrument or upon the security of a chattel mortgage, that the buyer of such property negotiate any policy of insurance covering such property through a particular insurance company, insurance producer, or broker or brokers. However, this subdivision shall not prevent the exercise by any seller of such property or the one making a loan thereon of the right to approve or disapprove of the insurance company selected by the buyer to underwrite the insurance.

(13) Issuing, offering, or participating in a plan to issue or offer, any policy or certificate of insurance of any kind or character as an inducement to the purchase of any property, real, personal, or mixed, or services of any kind, where a charge to the insured is not made for and on account of such policy or certificate of insurance. However, this subdivision shall not apply to any of the following:

(A) Insurance issued to credit unions or members of credit unions in connection with the purchase of shares in such credit unions.

(B) Insurance employed as a means of guaranteeing the performance of goods and designed to benefit the purchasers or users of such goods.

(C) Title insurance.

(D) Insurance written in connection with an indebtedness and intended as a means of repaying such indebtedness in the event of the death or disability of the insured.

(E) Insurance provided by or through motorists service clubs or associations.

(F) Insurance that is provided to the purchaser or holder of an air transportation ticket and that:

(i) insures against death or nonfatal injury that occurs during the flight to which the ticket relates;

(ii) insures against personal injury or property damage that occurs during travel to or from the airport in a common carrier immediately before or after the flight;

(iii) insures against baggage loss during the flight to which the ticket relates; or

(iv) insures against a flight cancellation to which the ticket relates.

(14) Refusing, because of the for-profit status of a hospital or medical facility, to make payments otherwise required to be made under a contract or policy of insurance for charges incurred by an insured in such a for-profit hospital or other for-profit medical facility licensed by the state department of health.

(15) Refusing to insure an individual, refusing to continue to issue insurance to an individual, limiting the amount, extent, or kind of coverage available to an individual, or charging an individual a different rate for the same coverage, solely because of that individual's blindness or partial blindness, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(16) Committing or performing, with such frequency as to indicate a general practice, unfair claim settlement practices (as defined in section 4.5 of this chapter).

(17) Between policy renewal dates, unilaterally canceling an individual's coverage under an individual or group health insurance policy solely because of the individual's medical or physical condition.

(18) Using a policy form or rider that would permit a cancellation of coverage as described in subdivision (17).

(19) Violating IC 27-1-22-25, IC 27-1-22-26, or IC 27-1-22-26.1 concerning motor vehicle insurance rates.

(20) Violating IC 27-8-21-2 concerning advertisements referring to interest rate guarantees.

(21) Violating IC 27-8-24.3 concerning insurance and health plan coverage for victims of abuse.

(22) Violating IC 27-8-26 concerning genetic screening or testing.

(23) Violating IC 27-1-15.6-3(b) concerning licensure of insurance producers.

(24) Violating IC 27-1-38 concerning depository institutions.

(25) Violating IC 27-8-28-17(c) or IC 27-13-10-8(c) concerning the resolution of an appealed grievance decision.

(26) Violating IC 27-8-5-2.5(e) through IC 27-8-5-2.5(j) or IC 27-8-5-19.2.

(27) Violating IC 27-2-21 concerning use of credit information.

(28) Violating IC 27-4-9-3 concerning recommendations to consumers.

(29) Engaging in dishonest or predatory insurance practices in marketing or sales of insurance to members of the United States Armed Forces as:

(A) described in the federal Military Personnel Financial Services Protection Act, P.L.109-290; or

(B) defined in rules adopted under subsection (b).

(30) Violating IC 27-8-11-10, IC 27-8-11.1, or IC 27-13-15-5 concerning dialysis treatment.

(b) Except with respect to federal insurance programs under Subchapter III of Chapter 19 of Title 38 of the United States Code, the commissioner may, consistent with the federal Military Personnel Financial Services Protection Act (P.L.109-290), adopt rules under IC 4-22-2 to:

(1) define; and

(2) while the members are on a United States military installation or elsewhere in Indiana, protect members of the United States Armed Forces from;

dishonest or predatory insurance practices.".

Page 1, line 15, delete "is a:" and insert "**is:**".

Page 1, line 16, after "(A)" insert "**a**".

Page 1, line 16, after "child" insert "**of the policyholder or certificate holder**".

Page 2, line 1, delete "child" and insert "**an individual**".

Page 2, line 5, delete "dependent's" and insert "**individual's**".

Page 2, line 36, delete "policy holder," and insert "**policyholder,**".

Page 3, line 1, delete "the policyholder" and insert "**the:**

(i) policyholder;".

Page 3, line 1, after "or" begin a new line triple block indented and insert:

"**(ii) policyholder's**".

Page 3, line 1, after "spouse" insert "**;**".

Page 3, line 1, beginning with "until" begin a new line double block indented.

Page 11, between lines 14 and 15, begin a new paragraph and insert:

"SECTION 7. IC 27-8-5-29 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: **Sec. 29. An insurer shall, for purposes of coverage of a dependent of a policyholder or certificate holder under this chapter, do all of the following:**

(1) Provide to each policyholder or certificate holder at the time of application, amendment, or renewal of a policy of accident and sickness insurance written notice that:

(A) is provided in a document that is separate from any other document provided to the policyholder or certificate holder; and

(B) clearly explains:

(i) that a dependent of the policyholder or certificate holder will be covered upon the request of the policyholder or certificate holder; and

(ii) the manner and form in which the policyholder or certificate holder must request the coverage.

(2) Allow at least thirty (30) days after a policyholder or certificate holder receives the notice required by subdivision (1) for the policyholder or certificate holder to make a request for the coverage.

(3) If:

(A) the dependent's coverage was previously terminated due to the dependent's age; and

(B) the dependent is not yet twenty-four (24) years of age; allow the dependent to re-enroll for coverage under the policyholder's or certificate holder's policy or certificate.

(4) Comply with the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) concerning exclusions or limitations of coverage related to a disease or physical condition of the dependent that exists before re-enrollment under subdivision (3).

SECTION 8. IC 27-8-11-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 10. (a) The definitions in IC 27-8-11.1 apply throughout this section.**

(b) An agreement entered into under section 3 of this chapter

after April 30, 2008, must provide that if the insurer fails to pay, as specified by the agreement, for health care services rendered at a network dialysis facility, the insured is not liable for any sums owed by the insurer.

SECTION 9. IC 27-8-11.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 11.1. Dialysis Treatment

Sec. 1. Except as provided in this chapter, the definitions in IC 27-8-11-1 apply throughout this chapter.

Sec. 2. As used in this chapter, "dialysis facility" means an outpatient facility in Indiana at which a dialysis treatment provider renders dialysis treatment.

Sec. 3. As used in this chapter, "insured" refers only to an insured who requires dialysis treatment.

Sec. 4. As used in this chapter, "insurer" includes the following:

(1) An administrator licensed under IC 27-1-25.

(2) An agent of an insurer.

Sec. 5. As used in this chapter, "network" refers to a group of providers, each of which has:

(1) individually; or

(2) as a member of a group;

entered into an agreement with a particular insurer under IC 27-8-11-3.

Sec. 6. As used in this chapter, "network dialysis facility" means a dialysis facility that has entered into an agreement with a particular insurer under IC 27-8-11-3.

Sec. 7. As used in this chapter, "out of network dialysis facility" means a dialysis facility that has not entered into an agreement with a particular insurer under IC 27-8-11-3.

Sec. 8. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. The term does not include the following:

(1) Accident-only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy issued as an individual policy.

(6) A limited benefit health insurance policy issued as an individual policy.

(7) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(8) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

Sec. 9. To the extent that IC 27-8-11-4.5(c) and IC 27-8-11-4.5(d) conflict with the requirements of this chapter, IC 27-8-11-4.5(c) and IC 27-8-11-4.5(d) do not apply with respect to the requirements of this chapter.

Sec. 10. A policy of accident and sickness insurance must provide coverage for dialysis treatment regardless of whether an insured obtains dialysis treatment from a network dialysis facility or an out of network dialysis facility.

Sec. 11. An insurer that uses a network shall establish a payment rate for a health care service rendered by a dialysis treatment provider at an out of network dialysis facility:

(1) in consultation with the dialysis treatment provider; and

(2) based on the following:

(A) The type of health care service rendered.

(B) The fees usually charged by the dialysis treatment provider.

(C) The prevailing rate paid to a dialysis treatment provider by insurers in the same geographic area during the preceding twelve (12) months.

Sec. 12. In establishing a payment rate under section 11 of this chapter, an insurer shall:

(1) not consider Medicaid and Medicare payment rates; and

(2) establish the payment rate at an amount equal to not less than the greatest of the following payment rates paid by the insurer during the previous twelve (12) months:

(A) The highest payment rate paid to the dialysis treatment provider for health care services rendered at a network dialysis facility.

(B) The highest payment rate paid to the dialysis treatment provider for health care services rendered at an out of network dialysis facility.

(C) The highest payment rate paid to any dialysis treatment provider for health care services rendered at a network dialysis facility.

Sec. 13. An insurer may not do any of the following at any time after an insured elects coverage under a policy of accident and sickness insurance:

(1) Restrict benefits or increase costs to the insured in relation to dialysis treatment, including the insured's out-of-pocket expenses.

(2) Change coverage or benefits in any way that would affect dialysis treatment provided at an out of network dialysis facility.

Sec. 14. An insurer shall not do the following:

(1) Make changes in coverage under a policy of accident and sickness in an attempt to cause an insured to elect Medicare as the insured's primary coverage.

(2) Require an insured, as a condition of coverage, to travel more than fifteen (15) miles or for longer than thirty (30) minutes from the insured's home to obtain dialysis treatment, regardless of whether the insured chooses to receive dialysis treatment at a network dialysis facility or an out of network dialysis facility.

Sec. 15. An insurer shall do the following:

(1) Make all claim payments for health care services provided by a dialysis treatment provider payable only to the dialysis treatment provider and not to the insured, regardless of whether the health care services are rendered in a network dialysis facility or an out of network dialysis facility.

(2) File with the department, not later than December 31 of each year, an annual evaluation of the following:

(A) Whether the insurer's network of all dialysis treatment providers is sufficient to provide health care services to insureds covered under a policy of accident and sickness insurance issued by the insurer.

(B) A detailed analysis of whether the requirements of section 14(2) of this chapter are reflected in the actual distance and travel time required for insureds to obtain dialysis treatment.

(3) Maintain a network that at all times includes not less than fifty percent (50%) of the dialysis facilities in the geographic area in which health care services are provided by the network.

Sec. 16. The commissioner shall, not more than thirty (30) days after receiving a filing under section 15(2) of this chapter, approve the filing or make recommendations for changes to the network.

Sec. 17. The department may adopt rules under IC 4-22-2 to implement this section.".

Page 11, line 19, delete "is a:" and insert "**is:**".

Page 11, line 20, after "(A)" insert "**a**".

Page 11, line 20, after "child" insert "**of the subscriber**".

Page 11, line 22, delete "child" and insert "**an individual**".

Page 11, line 22, delete "," and insert "**or who is a**".

Page 11, line 23, after "relative" insert "**of the subscriber and**".

Page 11, line 26, delete "is an Indiana resident;" and insert "**resides with the subscriber at least six (6) months of the year, with exceptions for divorce, separation, or temporary absences, including absences for illness, education, business, vacation, or military service;**".

Page 11, between lines 33 and 34, begin a new paragraph and insert:

"SECTION 11. IC 27-13-1-11.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 11.6. "Dialysis facility" means an outpatient facility in Indiana at which a dialysis treatment provider renders dialysis treatment.**".

Page 12, between lines 31 and 32, begin a new paragraph and insert:

"**(c) A health maintenance organization shall, for purposes of coverage of a dependent of a subscriber as required by subsection (a)(26), do all of the following:**

(1) Provide to each subscriber at the time of application, amendment, or renewal of a contract referred to in section 1 of this chapter written notice that:

(A) is provided in a document that is separate from any other document provided to the subscriber; and

(B) clearly explains:

(i) that a dependent of the subscriber will be covered upon the request of the subscriber; and

(ii) the manner and form in which the subscriber must request the coverage.

(2) Allow at least thirty (30) days after a subscriber receives the notice required by subdivision (1) for the subscriber to make a request for the coverage.

(3) If:

(A) the dependent's coverage was previously terminated due to the dependent's age; and

(B) the dependent is not yet twenty-four (24) years of age; allow the dependent to re-enroll for coverage under the subscriber's individual contract or group contract.

(4) Comply with the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) concerning exclusions or limitations of coverage related to a disease or

physical condition of the dependent that exists before re-enrollment under subdivision (3).

SECTION 13. IC 27-13-15-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 5. (a) Notwithstanding IC 27-13-1-12, as used in this section, "enrollee" refers only to an enrollee who requires dialysis treatment.**

(b) As used in this section, "health maintenance organization" includes the following:

(1) A limited service health maintenance organization.

(2) An agent of a health maintenance organization or a limited service health maintenance organization.

(c) To the extent that IC 27-13-15-1(b) and IC 27-13-15-1(c) conflict with the requirements of this section, IC 27-13-15-1(b) and IC 27-13-15-1(c) do not apply with respect to the requirements of this section.

(d) An individual contract or a group contract must provide coverage for dialysis treatment regardless of whether the dialysis facility from which an enrollee obtains dialysis treatment is a participating provider.

(e) A health maintenance organization shall establish a payment rate for a health care service rendered by a dialysis treatment provider at a dialysis facility that is not a participating provider:

(1) in consultation with the dialysis treatment provider; and

(2) based on the following:

(A) The type of health care service rendered.

(B) The fees usually charged by the dialysis treatment provider.

(C) The prevailing rate paid to a dialysis treatment provider by health maintenance organizations in the same geographic area during the preceding twelve (12) months.

(f) In establishing a payment rate under subsection (e), a health maintenance organization shall:

(1) not consider Medicaid and Medicare payment rates; and

(2) establish the payment rate at an amount equal to not less than the greatest of the following payment rates paid by the health maintenance organization during the previous twelve (12) months:

(A) The highest payment rate paid to the dialysis treatment provider for health care services rendered at a dialysis facility that is a participating provider.

(B) The highest payment rate paid to the dialysis treatment

provider for health care services rendered at a dialysis facility that is not a participating provider.

(C) The highest payment rate paid to any dialysis treatment provider for health care services rendered at a dialysis facility that is a participating provider.

(g) A health maintenance organization may not do any of the following at any time after an enrollee elects coverage under an individual contract or a group contract:

(1) Restrict benefits or increase costs to the enrollee in relation to dialysis treatment, including the enrollee's out-of-pocket expenses.

(2) Change coverage or benefits in any way that would affect dialysis treatment rendered at a dialysis facility that is not a participating provider.

(h) A health maintenance organization shall not do the following:

(1) Make changes in coverage under an individual contract or a group contract in an attempt to cause an enrollee to elect Medicare as the enrollee's primary coverage.

(2) Require an enrollee, as a condition of coverage, to travel more than fifteen (15) miles or for longer than thirty (30) minutes from the enrollee's home to obtain dialysis treatment, regardless of whether the enrollee chooses to receive dialysis treatment at a dialysis facility that is a participating provider or a dialysis facility that is not a participating provider.

(i) A health maintenance organization shall do the following:

(1) Make all claim payments for health care services provided by a dialysis treatment provider payable only to the dialysis treatment provider and not to the enrollee, regardless of whether the health care services are provided in a dialysis facility that is a participating provider or a dialysis facility that is not a participating provider.

(2) File with the department, not later than December 31 of each year, an annual evaluation of the following:

(A) Whether the health maintenance organization's network of all dialysis treatment providers is sufficient to provide health care services to enrollees covered under an individual contract or a group contract entered into by the health maintenance organization.

(B) A detailed analysis of whether the requirements of subsection (h)(2) are reflected in the actual distance and travel time required for enrollees to obtain dialysis

treatment.

(3) Maintain a participating provider network that at all times includes not less than fifty percent (50%) of the dialysis facilities in the health maintenance organization's service area.

(j) The commissioner shall, not more than thirty (30) days after receiving a filing under subsection (i)(2), approve the filing or make recommendations for changes to the network.

(k) The department may adopt rules under IC 4-22-2 to implement this section.".

Page 12, after line 40, begin a new paragraph and insert:

"SECTION 15. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 331 as reprinted January 29, 2008.)

FRY, Chair

Committee Vote: yeas 8, nays 1.